School Physicians' Bulletin

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Should Medical Inspection of Schools be Performed under the Auspices of the Board of Health or the Board of Education*

By WILLIAM C. HASSLER, M.D.,
President A. P. H. A.; Health Commissioner of City of San Francisco, Calif.

As the Health Officer of a metropolitan city wherein the medical inspection of all children in the schools whether public, parochial or private has always been harmoniously administered by the Department of Public Health, I shall endeavor to present my argument in an equitable and dispassionate manner, although for many years thoroughly convinced in my own mind that this question should have ceased to be the subject of controversy.

Boards of Health have always regarded children from five to fifteen as children of "school age" rather than "school children." This age group constitutes one-fifth of the total population. It is especially susceptible to the communicable diseases, and the school offers strategic opportunities where the foundation for health in later life must be securely laid. Health Departments also take the attitude that, as the schools have the children under their control but five hours out of the twenty-four of each day, and for a maximum of only 195 out of 365 days of the year, they are not capable of carrying on any well conceived or extensive program for the health supervision of this group. Would Health Departments be justified then in turning over to any other group the responsibility for the health of only a part of the population for only a part of the time? Moreover in communities where health work in schools is under school control, the department of public health must not only carry on a communicable disease program in the public schools but if cognizant of its responsibilities to public health it is compelled to organize a complete system of medical inspection within private and parochial schools. If the machinery for health work must be in operation for this large

*Read before the Third Annual Convention at Fort Worth, Texas, October, 1930.

school group, why spend the taxpayer's money for duplication of administrative set up in or under a Board of Education.

Educational authorities place their argument mainly upon the following: while the children are in school they are, and must necessarily be, directly under control of the educational authorities; all teaching is their function, whether it be that of health or other subjects; and any divided authority or responsibility leads to confusion and inefficiency.

Let us concede this point. But the responsibility of the Boards of Education ends with the teaching of health habits, etcetra, and the responsibility of the Health Department continues; for the physical wellbeing of the school age child is but a sequence of the work begun in the pre-natal period, and followed during the infant and pre-school ages.

Pre-natal education, infant welfare work and pre-school examinations are phases of health work now granted to health departments without argument. Is it not inconsistent that the child should be removed from the watchfulness of the Health Department during school age, only to be returned to it while still in its adolescent period and then for control and direction as an adult.

In the very beginning in many instances, at least, educational control has resulted from preparedness and expediency rather than because of the recognition that the health supervision of school children has become a coördinated function of a Board of Health program outlined for the community.

Educators very early recognized the fact that the Health authorities had neither the money, machinery, the support and often lacked the initiative to inaugurate, or carry on the work. This was particularly true in the smaller cities, towns and rural communities where there existed only part-time Health officers. While on the other hand the public readily responded to any request associated with the education of children and supported mandatory legislation which allowed any expenditure deemed necessary for fulfilling the educational program.

I contend that public health administration of child hygiene with which medical inspection of schools is so intimately integrated, whether it be physical fitness, discovery and correction of defects, mental hygiene, child guidance work or communicable disease is purely and solely a medical problem and in the very nature of things falls within the purview of a Board of Health and not under a Board of Education.

We have been reminded quite recently by a leading educator that the rapid development of health work in schools during the last two decades is not to be regarded merely as an educational reform, but rather as a corollary of a widespread realization of the importance of preventive measures in the conservation of human resources. When Health Inspec-

tion in Schools had its inception, Health Departments were almost solely expending their energies on the enforcing of measures to prevent the spread of communicable disease. As the public has become more and more health conscious, health departments have broadened their field, and have become increasingly popular as the source of health information and health education.

If the conservation of human resources is not the function of the Board of Health I hope that the discussion elicited by this paper will determine to whom this activity belongs. Medical inspection of school children is the very embodiment of preventive medicine and logically falls within the jurisdiction of properly constituted public health administration.

We all glory in the child hygiene movement in our country and in its division of medical inspection of schools no matter under whose authority administered; in its uninterrupted achievements and in its inevitable contribution to a greater national integrity.

I am convinced that organizations of medical inspection of schools, both under boards of health and education, have in many instances considerably overstepped the bounds of ethical propriety in an encroachment upon curative medicine.

I am in hearty accord with the succinct statement made a few years ago by a well known child hygienist regarding the true function of the school physician.

"When physical defects are found to exist, it is not the province of the school physician to do more than indicate their existence. Fine diagnoses with regard to each defect and suggestions of methods of treatment do not lie within his field. This belongs to the private physician or to the hospital or dispensary, while the method of treatment must always be decided upon by the family acting upon the advice of the physician in charge of the case. The purpose of school medical inspection in this regard is served when the attention of the family is called to the fact that the child is abnormal in some specific manner and needs competent and careful attention toward the defect which has been noted."

And now, a word concerning the public health nurse who has become a most effective instrument in public health administration. The school nurse employed by the educational authorities, with duties within the school and confined to the follow-up of correctible defects only necessarily has a field of limited usefulness, with no participation whatever in the community health program, as administered by the board of health. Public Health Nurses under the Health Department are doing every phase of Public Health Nursing. It is not only much less expensive to the community to include school Nursing in this program, but a great deal of confusion in standards of procedure and technique is saved by having one administrative authority responsible for all public health work.

With the present ideal standard of one public health nurse for every 2,000 of population, the trend is toward the pooling of nursing staffs and the limiting of all unnecessary duplications.

The discussion of generalized nursing in connection with the subject matter of my paper may at first thought seem slightly irrelevant, but it has an important bearing on school nursing when such a function is administered by the board of health. In San Francisco we now have two districts of generalized nursing and two additional districts in the process of formation. The set up of a generalized district is a conveniently situated district center, a supervisory nurse, five field nurses, a physician and a part-time dentist, a dental hygienist, a baby welfare center and on certain days a mental hygienist and psychologist. In these districts the field nurses not only function within the school but they do all other types of field nursing with the one exception of actual formal bedside nursing.

Generalized nursing is now an acknowledged advancement in public health administration and has developed in consequence of an awakening health consciousness among the people for higher standards of healthful living. Its trend is logical and its uninterrupted development inevitable.

The generalized nurse because of the nature of her multifarious duties is in strategic position to dramatize to school principals, to teachers, and most of all to children, the principles and potentialities of all phases of hygiene and preventive medicine.

Generalized nursing has effected a desirable intimacy and contact between the school and home. It has broadened the sociological horizon of the school principal and her teachers, and it has developed in them a sociological interest in their children, commensurate with their pedagogic responsibilities.

A prominent school principal of San Francisco recently said, "I highly commend your system of generalized nursing and I feel myself fortunate that my school is situated in such a district. In the absence of the school nurse I am always at liberty to communicate with the District Center for a prompt and efficient solution of the many problems that occur within the school."

No such desirable situation in public health administration is possible of consummation in communities where medical inspection of schools is administered by the local educational authorities, as school nursing forms the nucleus around which a generalized program is built. To place school medical inspection under the Board of Education is to strike a fatal blow to a generalized nursing plan.

Let the school hold tenaciously to the science of teaching, and incorporate into educational curricula within the classroom and in devious

other ways the teaching of health and hygiene, a subject which is one of the most important before the American people today.

Above all inculcate in little, impressionable children who have no conception of biologic cleanliness the importance of daily health habits. To the school there remains to develop in all children a proper health consciousness which will make for a high degree of physical wellbeing and an adequate spirit of coöperation with the purposes of public health.

We all deprecate the law in its lamentable failure to keep step with the psychiatrist and mental hygienist in our present accepted knowledge of the mental hygiene movement. We see a true analogy to this, in our erudite educators who fail to recognize Board of Health authority for health work in schools as a necessary auxiliary in the development of a public health child hygiene program.

To me an amicable adjustment would be in making both boards responsible for the health control of school children, and having these boards work in coöperation. That this can be successfully accomplished is evidenced in New York, Philadelphia, and Cleveland. As Boards of Education can more easily obtain the necessary funds, it would seem expedient to have all employes of school medical inspection paid by the board of education, with the board of health, the custodian of the health of the whole community, responsible for efficient administration and results.

In closing I have but one thought, and it is not unreasonable to ask that the leading educators investigate with an open mind the work that is now being accomplished by the various bureaus of child hygiene throughout the country under health department control, to the end that they may complacently yield to public health authority in the administration of medical inspection of schools.

What Toxin-Antitoxin Has Done

The use of toxin-antitoxin as a preventive of diphtheria has been much more general in the United States than in European countries. If this biological product fulfills its purpose, we should expect as a result a much lower prevalence of diphtheria here than abroad. An examination of the statistics show this to be the case.

From the epidemiological reports of the League of Nations and from statistics compiled by the U. S. Public Health Service for this country, it is learned that case reports of diphtheria from 27 European countries and for the United States for the last few years are as follows:

CASES OF DIPHTHERIA

	1927	1928	1929	1930
United States	106,191	91,156	85,365	61,564*
27 European Countries..	257,959	296,070	327,391	.....

* Provisional. Compiled from weekly telegraphic returns.

In Europe the prevalence rate varies noticeably in different nations and in the political sub-divisions of some of the nations. Likewise in the United States the rates vary in different states and in different cities. Where the toxin-antitoxin campaigns have gone forward with the greatest vigor and largest degree of success, there the diphtheria prevalence rate has decreased most rapidly.—*Illinois Health Messenger*, Feb. 15, 1931.

Corrective Physical Education Practiced in Los Angeles City Schools

By SVEN LOKRANTZ, M.D.,
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Nine years ago the Department of Health and Corrective Physical Education, Los Angeles City Schools, organized a Corrective Physical Education Section, the development and expansion of which has been rapid and steady. Corrective rooms with corrective teachers are now an integral part of every junior and senior high school; and the elementary schools are supplied with thirteen corrective physical education centers for nearby schools while those more distant are cared for by traveling corrective teachers. This comparatively new division of the Department of Health and Corrective Physical Education is now able to reach and help about 50,000 children. The children considered are those having poor posture, flat feet, nutritional disturbances, paralysis, and heart defects.

The story of Corrective Physical Education for the school children of Los Angeles is almost unbelievable. It has gone through an evolution of years of struggle and has finally become accepted and praised, not only by parents but by the medical profession and all creeds. The President of the County Medical Society made the statement before a medical body this year that we are building a new race in Los Angeles; and the present plan is being adopted not only in this country but also in countries abroad.

Procedures for correction are: free floor corrective group gymnastics, individual corrective gymnastics, orthopedic gymnastics, non-surgical orthopedics, rest, diet, sun baths, strappings and home exercises.

There are about 35,000 children with different abnormal postural conditions, such as round shoulders, spinal curvatures, and depressed chests. These children, if not helped, will fail to develop into strong men and women. Hygiene, rest, corrective exercises, jackets and general corrective procedures will give astounding results in a short time.

There are 8,000 children with heart defects who have been aided by

the Department of Health and Corrective Physical Education. Children with heart defects are excused from regular physical training and assigned to corrective physical training classes. By giving such children an opportunity to rest and by giving them graded exercises to enlarge their chest capacity, we increase the opportunity for longer lives.

In most of the elementary schools, we find a great number of heart cases which demand investigation, examination and re-examination. The problem of handling these cases is a very important one. The functional heart conditions and minor lesions are handled in groups of from ten to twenty-five, and special heart exercises are given. Other more serious lesions, like aortic regurgitation, mitral stenosis, and double lesions come under the care of private physicians or the heart board.

The muscle of the heart is under the same law of physiology as any other muscle of the body, and if it is not given proper care, it may be strained, overworked or wasted. It is quite interesting to note that heart affections are more prevalent among children in some schools than in others. The elimination of worry and excitement in the cases of children suffering from heart affection is important. If a child with a heart defect is sensitive and if the teacher is in any way indiscreet in her remarks during his daily recitations, that child is seriously hurt by constant excitement and worry. Relief from worry is a prime essential in the case of such children.

There are many thousands of children with pronated feet in the Los Angeles City Schools. Corrective exercises, shoe corrections, and strappings have afforded help and, in some cases, have effected a cure.

New schools and additional teachers make a total of twenty-three senior high schools and seventeen junior high schools doing either full or half time corrective work. Nine of the senior high schools have but a half time assignment and six of the junior high schools have only half time. One high school has two full time teachers and another has additional help for two periods.

In every school where there is a teacher doing even part time, there is a room and partial equipment. This year more equipment has been received and some of the places which were seriously handicapped are rejoicing over improved surroundings. More adequate rest rooms have been added in some schools; and this aids the work, as it eliminates students resting in the gymnasiums at the time a class is in progress, a practice which is detrimental to both groups involved.

Some of the schools have added archery and clock golf as part of the corrective program. These and other games serve chiefly as a means of varying the program and stimulating interest. One school is planning a play day for "corrective" girls for the next year.

Perhaps one of the most valuable achievements has been the improvement in attitude or mental concept of students in these special classes. Most of the teachers report that the girls have shown a keen desire to fully understand their own physical handicaps and that they carry their work on into other activities.

Interest and enthusiasm on the part of the students have increased. Many of the teachers reported special conference periods before school, during lunch hour, and after school. At these appointed times, the girls and boys came and presented their personal problems. Since this type of work is stimulated by individual interests, we feel that the provision for these conferences is truly a step forward.

Another difference has been the change in attitude of the entire student body toward the students in corrective classes. Assignment is considered an opportunity and special privilege rather than a duty. In many instances, students and their parents have requested the assignment to a corrective class although such was not indicated on the health card.

Increase in the number of home schedules of exercise has been another indication of progress. There is the realization that persistent application to the work of correcting physical defects is the only means for obtaining results. It is a continuous process, and repeated observance of the daily schedule does much to give the student the right mental attitude and a mental conception of good posture.

The elementary corrective physical education section consists of one full time and one part time pediatrician, one part time orthopedic surgeon, one special nurse, nineteen corrective teachers, and one assistant supervisor. These are conducting thirteen corrective centers and the part time corrective work in fifty-five schools.

This past year 7,514 children received attention in the elementary schools. Of this number 1,189 have been dismissed improved, and 915 have been dismissed corrected. 6,166 defects were removed.

In addition to the splendid work in the elementary corrective centers, the work of the traveling teachers has eliminated the transportation problems. It has been possible to take care of more children with less expense and equipment. Also the traveling teacher has a more personal contact with the principals.

A special kindergarten work further consists of a special kindergarten teacher, directing a health program which can be adapted to activities of the kindergarten. This has been successfully accomplished by demonstration lessons and visits to kindergartens, with suggestions offered for varying needs in different communities. The kindergarten teachers of Los Angeles have responded quickly to all help offered and have requested assistance repeatedly. This shows their long felt need for this work

and demonstrates their appreciation of the importance of health in the young child as a means of prevention of difficulties later in life.

This past year many children were referred to hospitals or private physicians for removal of defects; other children were given instructions as to diet, rest, or exercise according to individual needs. All teachers have made each child a study, trying to correct his particular defects.

From the kindergarten through the high school, there is a concerted effort to aid children who have certain handicaps. This is accomplished by pointing out the physical defects, and providing the necessary personnel and equipment. The time is coming when a similar service will be given all school children in this country—a service to which they are certainly entitled. We are spending hundreds of dollars each year in the United States for the education of each child, yet we are only spending a little more than one dollar a year on each child for health supervision. This fact is very distressing when we realize that the health of the child is far more important than its education. The old Greeks and Romans in the days of their glory spent half their money on their youths' education and half on health supervision.

Good News from Michigan

The State conference of the Michigan Public Health Association was held in Lansing, January 7, 8 and 9. Some time before the meeting, it was noted that the program contained very little in regard to school health service. A self appointed committee composed of Dr. Gudakunst of Detroit, Dr. Benning of Royal Oak and Drs. Brannock, Neafie, Monroe and Volk of Pontiac, decided to ascertain if school physicians and school nurses would be interested in holding a short post-conference session to discuss school health problems.

So much interest was expressed in the idea that such a meeting was arranged. The success of the luncheon far surpassed our expectations—over a hundred people attending. Over one hundred twenty-five others desired to attend, and being unable to obtain accommodations waited outside the dining room until after lunch was over in order to gain admission to the meeting. No long speeches were given. Questions relating to health problems of schools and the school child, previously written out and dropped into a question box, were read, answered and discussed by those present. Everyone was tremendously encouraged by the interest and enthusiasm manifested.

Dr. Slemons, State Commissioner of Health, was present. He congratulated the sponsors of the meeting and promised in the future to have a half day allotted to school health problems during the conference of the

Michigan Public Health Association. The meeting was a success, not only because of the large attendance, but by the enthusiasm shown.

The fact was established that a meeting at least once a year of all school health workers would be of interest and value.

Let us hope other States will soon follow this forward step taken by Michigan. To organize such "interest and enthusiasm" is certain to prove mutually helpful to all engaged in health service and to materially increase its efficiency.

Physical and Mental Fitness for Teaching

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Every term brings to the teacher the problem of the misfit child. In order to cope with it, the teacher herself must not be a misfit. A teacher is in a poor condition to improve physical handicaps in her pupils until she herself has been placed in as good physical condition as is possible. The teacher needs accurate vision and hearing more than does the pupil. Speech defects or an unpleasant voice lower her ability to convey her thoughts.

The importance of the problem of physical and mental fitness for teaching can be viewed from several angles. There is the economic aspect. It is a waste of school funds, and therefore an injustice to the taxpayer, to train a person, at state expense, for teaching when that person, on account of physical unfitness, will be absent often from the classroom, or will be an early candidate for disability compensation. Dr. Howe, of New York State, found that of those teachers retiring on account of disability, 50% were under the age of fifty.

There is also the Personal Aspect of the problem. The physically or mentally unfit teacher is likely to have a discontented and unhappy disposition; will worry much over her work, and very likely break under the nervous strain of the classroom. Such teachers supply most of the disciplinary and administrative personal problems. It is true that many teachers who are unfit to teach because of physical or mental defects, will eliminate themselves. But what a waste of time and money.

More important than either the economic or personal, is the Educational Aspect. The teacher who is regularly or frequently absent from school on account of illness certainly cannot do the most effective work. The teacher who has some repulsive physical defect will have a depressent influence upon some pupils. The teacher whose voice is unpleasant or

cannot be understood, who cannot see well, or who has difficulty in hearing is certainly not fit to do a first class job of teaching. The teacher who is cranky, irritable or a trouble maker is sure to have a very unhappy and disorderly group of pupils. The teacher who is physically unable to participate in the playground activities of her pupils, to get about the room, up or down stairs with facility is greatly handicapped in the work of teaching where that type of activity is desirable. It is realized that examples can be given of most excellent teachers with various types of physical defects. So, too, can many examples be found of most excellent teachers with little academic or professional schooling, yet we would not allow these to lower the standards of intellectual requirements. The school physicians of the country have placed the number physically and mentally unfit at about 3 to 10%, and a letter to some 200 principals of both elementary and high schools elicited the information that their estimate placed the number of incompetents at from 6 to 12%.

From 500 replies received from physicians and principals, it seems that the following defects should disqualify a teacher permanently: Strabismus, speech defect, toxic goiter, serious cardiac defects, active tuberculosis, major orthopaedic defects, unsightly blemishes, and emotional instability.

Some of the defects that should disqualify until remedied are diseases of the gums or teeth, blood pressure of 150 or more, anemia, dysmenorrhea causing regular absences from duty of a day or more, any infectious disease, marked overweight if it handicaps physical activity, and 20% underweight.

The one phase that most physicians mentioned as being very undesirable was "Emotional Upset." This they feel should be carefully checked and should disqualify if at all serious. Under this item is mentioned sex perversions, temper, nagging, untidiness, crankiness, and a number of other expressions of mental instability.

Any list of disqualifying defects should be used only as a guide as it would be dangerous to be bound by any set rule because exceptions would be sure to come up and cause trouble.

The problem of determining the physical and mental fitness for teaching is an immediate problem for all who are connected with the teacher training institutions throughout the entire country.

The elimination of the unfit, especially if it can be done before the period of teacher training is begun, would result in a great saving in time and money for all concerned. May I tell how some of the teachers' training institutions are approaching the problem?

The Philadelphia Normal School, which is the chief source of grade teachers for that city, has a set of rules that provides that "No person

having any physical or mental defect either acute or chronic will be admitted to registration in the classes, nor shall such a person be allowed to graduate even after completing the course of study." The State Teachers' Training School in Milwaukee requires all its candidates to present a very detailed examination blank filled by a licensed physician, before they are admitted and then this blank is reviewed by the school authorities. Students having serious defects are rejected unless such defects are corrected. At the Harris Teachers College in St. Louis, it is the health policy to examine all freshmen in the St. Louis High Schools and those girls who intend to become teachers are advised to have all remedial defects corrected during the high school course. A second check is made on all freshmen entering the teachers college.

The Connecticut State Board of Education has probably gone farthest along the line of health standards for applicants for admission to the state normal schools. It is one of the requirements for admission, rather than, as is usually the case, a requirement after admission. They have adopted a list of causes for rejection as well as a list of causes for conditional admission.

At Fresno State College in California, essentially a teachers' college, the plan is to have not less than three physical examinations during the four-year teacher's training course. One at entrance, one at the end of the second year, or before the candidate is allowed to start practice teaching, and the third before graduating or receiving their teacher's credential. Any freshman having a disqualifying defect is advised to choose some other vocation, as it will be impossible to receive credentials even though the training is completed. If the defect is remediable the student is followed closely, given every assistance possible to overcome the trouble, but if such defect is not corrected by the end of the second year, she is not allowed to start her practice teaching the next or third year, not until such defect is corrected.

It is to be noted that in nearly all reports that the physical condition is the one thing that is stressed, yet in about 75% of the letters from school physicians and school principals the mental and emotional instability is that which is emphasized as making many teachers unsatisfactory in their positions.

It is fairly easy to get a consensus of opinion as to a list of physical defects that should bar a candidate from the teaching profession, but when we come to the temperamental side of personality, there is an entirely different condition. There are some very good reasons why this is so

Psychologists have not, so far as I know, established any accurate test by which a teacher candidate could be examined and her emotional state rated. Dr. Robert Woodworth has developed a group of test questions

which give some insight into emotional instability of certain types. Dr. Carl Jorgensen presented in his paper before the Whittenberg Symposium on Feelings and Emotions, a classification of emotions that is well worth presenting as a foundation for further investigation. Dr. Jorgensen classifies six elements as being fundamental to the emotions and that all emotions can be classified as one or a combination of these elements. Fear, happiness, sorrow, want, anger, and shyness.

It is the purpose at our institution in California to have all the teacher candidates rated on some such a scale by each of their classroom instructors and especially by the supervising teacher who watches them during their practice period of teaching. To supervise this and to receive reports from any other source there is a Personal Committee composed of four faculty members who have as their consultants the two Deans and the Medical Director. In this way we hope to have an insight into the emotional character of the prospective teacher.

Physical Qualifications of Children as to Activity Assignments

Physical Directors receive many notes from family physicians, requesting upon the part of their school patients non-participation in gymnasium activities. Often the ailments are not mentioned or the time limits specified. We can understand why physicians, from a legal standpoint, hesitate to place the ailments of their patients upon notes that may come to the attention of several people. We can also appreciate his desire to please his patients who too often ask him to write excuses based upon insufficient reasons.

In many places the physical qualifications of children as to activity assignments rests upon the joint decision of the family and the school physician. This desirable coöperation is effected through the family physician filling out a request card in which he specifically mentions the cause of incapacity and its probable duration. The school physician checks the family physician's findings and either does or does not concur in the recommendations.

They may disagree since there are no commonly accepted standards published to which they may turn for guidance. For example, a family physician desires that his patient be excused from an activity assignment because of low vitality attended by a weak musculature. He recommends rest periods. The school physician refuses to concur with this recommen-

dation since he holds that weak muscles are the cause of faulty posture and a low vitality. Consequently, the pupil should seek to adjust himself to the athletic program of the school.

President Lokrantz of the American Association of School Physicians has appointed a Committee upon the Physical Qualifications of Children as to Activity Assignments. The committee includes the following: Dr. Lyman W. Childs, Cleveland, Ohio, Chairman; Dr. C. C. Wilson, Evansville, Ind.; Dr. Allen C. Ireland, Trenton, N. J.; Dr. Arthur C. Schaefer, Buffalo, N. Y.; Dr. F. W. Maroney, New Haven, Conn.; Dr. C. Morley Sellery, Los Angeles, Cal.; Dr. Lillian DeArmit, Worcester, Mass.

Morbidity from Heart Disease

The New York State Department of Health, assisted by nearly one thousand physicians, exclusive of New York City, is conducting a study of the morbidity from heart disease.

The project has the endorsement of the State Medical Society, the State Education Department and the American Heart Association.

Except in 1918, when pneumonia followed by influenza held first place, heart disease has been the leading cause of death for eighteen years. In 1929 practically one of every four deaths was due to heart conditions.

The Division of Vital Statistics of the State Health Department will collate and analyze the observations and experience of the coöperating physicians and will make public the results from time to time.

A brief report will be given to the School Physicians at the Montreal Meeting so far as it relates to children.

The following blank is being used:

SURVEY OF MORBIDITY FROM DISEASES OF THE HEART

Confidential report by.....M. D. Date.....
.....P. O.

Name of patient.....Age.....Sex.....Color.....
Single..... Married..... Widowed..... Divorced..... Country of birth..... Occupation.....
Have others in family heart disease? Yes.... No.... Unknown....
If so, what was their age when disease was disovered.....
Etiology
1 Rheumatic fever..... Date of first attack.....
2 Chorea .....
3 Syphilis..... Date of chancre.....
4 Other infection (specify organism).....
State nature of infection (diphtheria, etc.).....

5 Congenital .....
6 Chronic high blood pressure.....
7 Thyrotoxicosis .....
8 Other causes (specify).....
9 Etiology unknown .....
10 Nervous heart .....

Pathology

1 Pericardial disease: (a) Inflammation..... (b) Effusion.....
2 Damage to valves, state valve affected.....
3 Aortitis..... Aneurism.....
4 Damage to coronary vessels.....
5 Damage to myocardium.....

Course of patient's disability

State date or age of patient at beginning of:
(a) Cardiac symptoms .....
(b) Occasional rest in bed.....
(c) When patient first became bedridden.....
(d) When patient became permanently bedridden.....

Type of treatment

1 Removal of foci of infection: (a) Tonsillectomy.....
(b) Other foci (specify).....
2 Anti-luetic treatment .....
3 For hypertension .....
4 Cardiac treatment: (a) By drugs..... (b) by rest.....
5 Other treatment .....

Remarks:

New Members Since Last Published List

Dr. H. W. Newell.....3343 Tullamore Road, Cleveland, Ohio
Dr. E. W. Richards.....Easton, Penna.
Dr. Samuel Ash.....25 Johnston Ave., Newark, N. J.
Dr. John L. Groh.....419 Cumberland St., Lebanon, Pa.
Dr. J. H. Lang.....183 East Commonwealth Ave., Fullerton, Calif.
Dr. E. Harrison Ormsby.....37 Church Street, Amsterdam, N. Y.
Dr. Bernard Fein.....98 Shanley Ave., Newark, N. J.
Dr. James G. Flynn.....14 South Mill Street, Ridgway, Penna.
Dr. W. T. Holland.....914 Pittsburgh Street, Springdale, Pa.
Dr. Jennie D. Beaver.....43 Elm Street, Morristown, N. J.
Dr. Edwin B. Murchison.....1351 Logan Ave., Tyrone, Pa.
Dr. Arthur M. Johnson.....82 Chestnut St., Rochester, N. Y.
Dr. Ethel Emerson.....19 East 98th Street, New York City

Dr. Emily R. Shipman.....Mt. Carmel, Pa.
Dr. Stephen A. Mahady.....12 Prospect Street, Utica, N. Y.
Dr. J. R. Beaver.....100 Luzerne Ave., West Pittston, Pa.
Dr. Chas. B. Dotterrer.....Boyertown, Penna.
Dr. Oscar T. Ziel.....412 Chartiers Drive, McKees Rocks, Pa.
Dr. C. S. Bridenbaugh.....Emlenton, Penna.
Dr. Chas. J. Prohaska.....130 Washington Street, Hartford, Conn.
Dr. A. K. Lewis.....803 Amity Street, Homestead, Penna.
Dr. Anna M. Gove.....517 Highland Ave., Greensboro, N. C.
Dr. George L. McKee.....Burgettstown, Penna.
Dr. M. G. Miller.....Northampton, Penna.
Dr. H. C. Hackman.....East McKeesport, Penna.
Dr. Oscar E. Hofmann.....West Hazleton, Pennaa.
Dr. R. H. Person.....Athens, Penna.
Dr. Wm. L. Martin.....Merion, Penna.
Dr. W. C. Schultz, Jr.....Waynesboro, Penna.
Dr. A. E. Dann.....Canton, Penna.
Dr. E. F. McGinty.....Olyphant, Penna.
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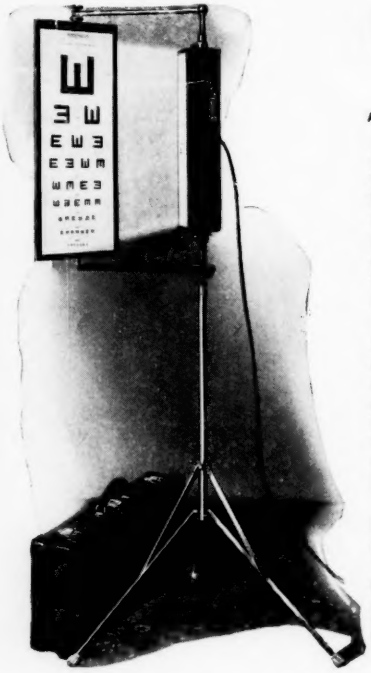

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